

Developmental Disabilities Administration
Self-Directed Services ~ Community Pathways Waiver
Agreement

Parties: This Self-Directed Services Agreement (referred to hereafter as “Agreement”) is between the Maryland Department of Health and Mental Hygiene, Developmental Disabilities Administration,
AND

Name of Self-directing Participant: _____
 Address: _____

Name of Participant’s Guardian (if applicable): _____
 Address: _____

As the Self-directing Participant, I have been informed of my responsibilities in participating in the *Self-direction ~ Community Pathways Waiver Program* and hereby authorize the individual named below as my Support Broker to assist me in understanding and administering this Self-Directed Services Agreement:

Name of Support Broker: _____
 Address: _____

Signature of Support Broker: _____ Date: _____

Purpose: To define my responsibilities as the Participant/Support Broker to buy specific services and supports identified in this Agreement.

Disbursement of Funds: The funds identified in the approved Individual Plan and Budget (IP&B) will only be used to pay for actual services rendered. All payments will be made through a Fiscal Management Service under contract with the DDA. The Fiscal Management Service I selected is _____. Payments will only be issued and mailed directly to an actual employee, contractor, or vendor. Supporting documentation must accompany all requests for payment. The DDA will not pay for services that exceed the allocated budget amount, nor will the DDA pay for services or supports not identified in the approved IP&B. The DDA has authority over any individual budget amount that remains unspent at the end of a Fiscal Year. Neither the Participant, the Participant’s Guardian, nor the Participant’s Support Broker has any right to, or claim upon, the unused balance.

Participant/Support Broker’s Responsibilities: In addition to the requirements otherwise set forth in this Agreement, I will be responsible for the following duties. **Please initial each responsibility to show that you understand and agree to fulfill that duty.**

General Responsibilities:

- 1) I agree to comply with all program rules established by the DDA.
- 2) I agree to supply all required information to the Resource Coordinator and Fiscal Management Service.

- 3) **Record Keeping Responsibilities:** I agree that as the Participant/Support Broker, I will maintain copies of all required records for a minimum of five (5) years pursuant to §4-403 of the Maryland Health Annotated Code.
- 4) **Participant /Participant Guardian and Support Broker Liability:** I understand that as the Participant/Participant Guardian and/or Support Broker, I have sole responsibility for hiring staff to provide services on behalf of the Participant.

The DDA requires that a criminal background check be completed on all Support Brokers and staff who provide direct service care. As the Participant/Participant Guardian's and Support Broker, it is my full responsibility to screen, select, and train staff to protect the health and safety of the Participant. By choosing to participate in Self-Directed Services under the Community Pathways Waiver, I accept all liability for any harm to the Participant, or others, resulting from my action or inaction in conducting screening or tests on any employee, or in providing training in any specific area.

As the Participant/Support Broker, I further agree to indemnify (hold harmless) the Developmental Disabilities Administration, Department of Health and Mental Hygiene, and State of Maryland for the full amount of any judgment rendered against any one or more of them as a result of any action or inaction of any employee hired.

_____ I understand and agree to the responsibilities listed above regarding General Responsibilities. (Please initial)

Waiver Packet and SD IP&B

- 1) I understand that once the Waiver Packet is submitted by the Resource Coordinator to the DDA Regional Office, I must also submit the SD Plan and Budget to the Regional Office within 30 business days. If this is not received within 30 business days, then it will be assumed that I am no longer interested in pursuing Self-directed Services under the Community Pathways waiver.
- 2) Annual Plan Annual Updates (PAU): I understand that once enrolled in the CP Waiver, I am responsible for submitting a PAU for each new fiscal year, as required by the waiver.
- 3) I agree to immediately notify the Resource Coordinator and/or Support Broker of any changes or emergencies, which may require a change in the type or amount of services in the IP&B.

_____ I understand and agree to the responsibilities listed above regarding the Waiver Packet and IP&B (Please initial)

FMS and Billing

- 1) I agree to comply with all requirements of the Fiscal Management Service to ensure accurate records and prompt payroll, including: reviewing and signing employee time cards; verifying the accuracy of hours worked; ensuring the appropriate expenditure of funds; and completing all necessary tax information.
- 2) Review of Participant's Billings: I understand that the DDA, as well as the State Medicaid Agency, may review all billings submitted by the Participant/Support Broker to the Fiscal Management Service for payment and may deny payment if any charge is not properly supported

or is inconsistent with the approved IP&B. The Participant/Support Broker is still responsible to pay their employee(s) for any services actually provided.

____ I understand and agree to the responsibilities listed above regarding the FMS and Billing. (Please initial)

Staffing Responsibilities:

- 1) I understand that it is my responsibility to hire, fire, direct, and train staff to support the Participant as outlined in the IP&B.
- 2) I understand that if staff is not fully trained prior to the first day of work, they will not get paid. I understand that I am also fully responsible for ensuring that each staff member is qualified to provide the services for which they are hired or contracted. This includes FIRST AID and CPR training for all staff members, as well as Medical Technician training for staff members charged with providing medication to the Participant. When appropriate, I will also ensure that all specialized trainings, such as behavioral or person-specific training, are provided to staff **prior to the provision of services**. Failure to keep required trainings up to date will result in that staff person not being paid.
- 3) I understand that it is my responsibility to verify that all employees meet age requirements. An individual may not be paid to provide services or supports to his or her spouse.
- 4) If the SD Plan requires a vendor agreement, I understand that it is my responsibility to ensure that the vendor chosen is in agreement with the staffing terms above.
- 5) Unless otherwise agreed upon by the team, I agree to provide the Participant and DDA with 30 days written notice in the event that there are any changes in team members including but not limited to Support Broker, Nursing Services and Staff.

____ I understand and agree to the responsibilities listed above regarding Staffing Responsibilities. (Please initial)

Quality Assurance:

- 1) I understand that it my responsibility to notify DDA and the Resource Coordinator of all reportable incidents. I agree to comply with the following rules regarding Incident Reports:
 - a. As the Participant/Support Broker, I will submit an Incident Report to the DDA Regional Office and the Office of Health Care Quality within 24 hours of a Reportable Incident. Reportable incidents are significant events or situations that, because of the severity or sensitivity of the situation, shall be reported within prescribed timeframes to the Office of Health Care Quality and the DDA Regional Office.
 - b. The following situations are incidents that require the filing of a report:
 - i. Actual and suspected incidents of abuse, neglect, exploitation, or maltreatment.
 - ii. Loss of life.
 - iii. Unexpected or unplanned emergency room, hospital, or inpatient visit for a medical or psychiatric problem.
 - iv. Injuries that result in medical emergencies.
 - v. Police visits that result in a police report being taken.
 - vi. Any incident requiring the services of the Fire Department.

- vii. Any confirmed theft of an individual's property or funds valued over \$50.
 - viii. Medication errors requiring treatment by a medical professional or observation in a hospital.
 - ix. The unexpected or unauthorized absence of the individual for greater than four hours.
 - x. Unauthorized or inappropriate use of restraints or chemical interventions, or the use of any restraint that results in injury.
 - xi. Any incident that impacts or could impact the health and safety of an individual.
- 2) I understand that in addition, actual and suspected incidents of abuse, neglect, exploitation, or maltreatment shall be reported to the Adult Protective Services Authority or the Child Protective Services - Investigation of Child Abuse and Neglect Authority.
- 3) I agree to comply with any home or community visits to inspect program quality and conduct Agreement compliance reviews, and with the request of the DDA, administer customer satisfaction surveys.
- 4) In the event that DDA identifies concerns or issues regarding quality of services, I agree to correct the issue within the time specified by DDA.

 I understand and agree to the responsibilities listed above regarding Quality Assurance.
(Please initial)

Use of Public Funds: Should funds be awarded by DDA, I understand that they are public funds and as such they are subject to all applicable federal, state, and local laws and regulations pertaining to the use of public funds.

Misuse of Funds: I understand that the misuse of any funds awarded by DDA, is illegal and may lead to criminal prosecution, administrative sanctions, and liability for payment of misused funds. This includes but is not limited to using funds for purposes other than those specifically authorized.

Termination of this Agreement: I understand that this Agreement and Self-directed services may be terminated by me, the Participant/Participant's Guardian, at any time, or by the DDA with 30 days written notice. In addition, the DDA may immediately terminate this Agreement at any time upon discovery of misuse of funds or any other action taken by the Participant/Participant's Guardian or Support Broker pursuant to this Agreement that endangers the health and safety of the Participant.

Jurisdiction: The provisions of this Agreement are to be governed by and interpreted according to the laws of the State of Maryland. The parties shall submit to the jurisdiction of the courts of the State of Maryland for any dispute arising under this Agreement or relating to its breach.

Separability Clause: A finding by any court or other binding legal body that any part of this Agreement is illegal or void shall not affect the legality or enforceability of any other independent part of this Agreement.

Questions about this agreement should be directed to _____, your *Self-direction* Regional Coordinator.

As Participant/Participant's Guardian, my signature acknowledges that I have read, understand, and agree to all the terms of this Agreement. I understand that the failure to comply with any of the terms of this Agreement may result in my loss of privilege to receive Self-Directed Services under the *Community Pathways* Waiver now and in the future.

As Participant/Participant's Guardian, my signature also acknowledges that the DDA does not endorse or recommend any employee, contractor, or vendor to provide services under this Agreement.

Participant/Participant's Guardian

DDA *Self-direction* Regional Coordinator

Type or Print Name

Type or Print Name

Signature

Signature

Date: _____

Date: _____

People who helped me create this plan

By signing below I acknowledge my agreement with and approval of this plan

Waiver Applicant: _____ **Date:** _____

Parent (if waiver applicant under the age of 18): _____ **Date:** _____

Legal Guardian (if applicable): _____ **Date:** _____
